*****A physician must complete this document and review immunization records****. Please take your child’s vaccination records to the medical examination. Please turn in the completed forms to the Health Office in 1B76 or scan and email to*** ***nurse@tas.edu.tw******.***

**TAIPEI AMERICAN SCHOOL**

**Physical Exam Form**

**Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student ID number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_Pulse \_\_\_\_\_\_\_\_\_\_\_Visual Acuity: Right20/\_\_\_\_Left20/\_\_\_\_**

**Recent Hospitalization/Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Medical** | **Normal** | **Abnormal Findings (Physician to comment on all abnormal findings)** |
| **Neck** |  |  |
| **Eyes (pupils) ENT** |  |  |
| **Teeth** |  |  |
| **Chest** |  |  |
| **Lungs (Asthma and treatment)** |  |  |
| **Heart** |  |  |
| **Abdomen** |  |  |
| **Hernia** |  |  |
| **Neurologic** |  |  |
| **Skin** |  |  |
| **Spine/Back** |  |  |
| **Shoulders/Upper Extremities** |  |  |
| **Lower Extremities** |  |  |
| **Allergy (specify type and treatment)** |  |  |

On the basis of this examination, this student may participate in the school program, physical education class, and inter-scholastic sports. Physicians please mark below.

**­­­ CLEARED WITHOUT RESTRICTIONS**

**­­ CLEARED WITH THE FOLLOWING NOTATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NOT CLEARED FOR PARTICIPATION/REASON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE REVIEW IMMUNIZATION RECORDS WITH PARENTS Records seen: Yes No**

**Are immunization records complete? Yes No**

**If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature and Stamp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**THIS PAGE FOR MIDDLE AND UPPER SCHOOL ONLY**

**Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Health History Questions** |
| 1. |  |  | Have you had a medical problem, illness, or injury since your last exam?  |
| 2. |  |  | Do you have any chronic or recurrent illness? |
| 3. |  |  | Have you ever been hospitalized overnight? |
| 4. |  |  | Have you ever had any surgery other than a tonsillectomy? |
| 5. |  |  | Do you have any organs missing other than tonsils? |
| 6. |  |  | Have you ever had any other injuries requiring treatment by a physician? |
| 7. |  |  | Have you ever had a knee injury? |
| 8. |  |  | Have you ever had an ankle injury? |
| 9. |  |  | Have you ever injured any other joint (shoulder, wrist, finger, etc.)? |
| 10. |  |  | Have you ever had a broken bone or fracture? |
| 11. |  |  | Have you ever had a cast, splint, or had to use crutches? |
| 12. |  |  | Are you presently taking **ANY** medications (including birth control pills, vitamins, aspirin, etc.)? |
| 13. |  |  | Do you have **ANY** allergies to medication, bees, food, animal, latex, or other factors? Please have physician specify allergy and list treatment below. |
| 14. |  |  | Have you ever had chest pain, dizziness, fainting, or passing out during or after exercise? |
| 15. |  |  | Do you tire more easily or quickly than your friends during exercise? |
| 16. |  |  | Have you ever had any problems with your blood pressure or your heart? |
| 17. |  |  | Have any close relatives had heart problems, a heart attack, or sudden death before the age of 50? |
| 18. |  |  | Do you have any skin problems (eczema, rashes, itching, etc.)? |
| 19. |  |  | Have you ever had convulsions or seizures? |
| 20. |  |  | Do you have frequent, severe headaches? |
| 21. |  |  | Have you ever had a neck or head injury?  |
| 22. |  |  | Have you ever had heat exhaustion, heat stroke, heat cramps, or similar heat-related problems? |
| 23. |  |  | Have you ever had an asthma attack, trouble breathing, or coughing during or after exercise? |
| 24. |  |  | Do you wear eyeglasses, contact lenses, or protective eye wear? |
| 25. |  |  | Have you had any problems with your eyes or vision? |
| 26. |  |  | Do you wear any dental appliance such as braces, bridge, plate, or retainer? |
| 27. |  |  | Do you use special equipment for competition (pads, brace, neck roll, etc)? |
| 28. |  |  | Do you have any health concerns regarding your weight? |
| 29. |  |  | FEMALES: Have you had any menstrual problems?  |
| 30. |  |  | Do you have any medical or health concerns which would inhibit you from participating in sports or PE? |
| Physician, please comment on all “yes” answers. |  |  |  |

**Physician Signature and Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*As of May 14, 2015*